Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SOUTHWEST FRWY, SUITE 2200
HOUSTON TX 77027

Respondent Name

LIBERTY MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-08-1003-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This patient was brought to Memorial Hermann Hospital via ambulance and admitted through the ER due severe injuries sustained in the couse [sic] and scope of employment. The patient inhaled toxic vapors on the hob site which required immediate medical intervention and extensive medical treatment. The patient was hospitalized from October 4, 2006 through October 7, 2006." "Because this admit was for trauma/burn falling within diagnostic codes ISD9-800.0-959.5, the entire admission should be reimbursed at a fair and reasonable rate under Rule 134.401(c)(5)." "Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred. Requestor is owed an additional $32,805.72, plus interest."

Amount in Dispute: $32,805.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 4, 2006 through October 7, 2006	Inpatient Services	$32,805.72	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the reimbursement guidelines for inpatient hospital services.
3. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
4. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. This request for medical fee dispute resolution was received by the Division on October 5, 2007.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Z585-The charge for this procedure exceeds fair and reasonable.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - Z695-The charges for this hospitalization have been reduced based on the fee schedule allowance.
   - Z652-Recommendationof payment has been based on a procedure code which best describes services rendered.
   - X116-This payer denies this charge pending a statement documenting medical necessity.

Findings

1. 28 Texas Administrative Code §133.307(c)(1)(A), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires "A request for medical fee dispute resolution that does not involve issued identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." This request for medical fee dispute resolution was received by the Division on October 5, 2007. Therefore, disputed date of service October 4, 2007 was submitted untimely and will not be considered further in this decision.
2. The Respondent denied reimbursement for CT of head/brain w/o contrast based upon "X116-This payer denies this charge pending a statement documenting medical necessity." The disputed service was rendered on 10/4/2006. As stated above, this disputed date of service is filed untimely per 28 Texas Administrative Code §133.307(c)(1)(A).
3. The requestor indicates in the position summary that this inpatient hospitalization is subject to the provisions of 28 Texas Administrative Code §134.401(c)(5), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 983.1. The Division therefore determines that this inpatient admission is not a trauma/burn admission.
4. This dispute relates to inpatient medical services provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.401.
5. 28 Texas Administrative Code §134.401(b)(1)(B), effective August 1, 1997, states "Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(10), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital." A review of the submitted medical bill and itemized statement, indicate that the requestor billed for three inpatient medical days; therefore, this admission meets the definition of inpatient services per 28 Texas Administrative Code §134.401(b)(1)(B).
6. A review of the submitted hospital bill supports the primary services were medical in nature; therefore, the Division finds that this is a medical admission per 28 Texas Administrative Code §134.401(b)(1)(E).
7. 28 Texas Administrative Code §134.401(c)(1) states "Standard Per Diem Amount. The workers'

compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Medical $870."

8. The hospital admission was from October 4, 2006 through October 7, 2006; therefore, the length of stay was three days. Since date of service October 4, 2007 was submitted untimely; therefore, the eligible dates of service are October 5, 2006 through October 7, 2006.
9. 28 Texas Administrative Code §134.401(c)(1), states "Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows:

   Medical $870

   Surgical $1,118

   Intensive Care Unit (ICU)/Cardiac Care Unit (CCU) $1,560."

   A review of the submitted medical bill indicates that the requestor billed for three ICU dates.
10. 28 Texas Administrative Code §134.401(c)(3)(B), the reimbursement calculation formula is "LOS X SPDA = WCRA."

    A review of the submitted EOBs supports reimbursement of $4,680.00 ($1560.00 per day multiplied by three days); therefore, the requestor was paid in accordance with 28 Texas Administrative Code §134.401(c)(1).
11. 28 Texas Administrative Code §134.401(c)(4), states "Additional reimbursement. All items listed in this paragraph shall be reimbursed in additional to the normal per diem based reimbursement system in accordance with the guidelines established by this section. Additional reimbursement apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section."
12. 28 Texas Administrative Code §134.401(c)(4)(B), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (i) Magnetic Resonance Imaging (MRIs) (revenue codes 610-619); (ii) Computerized Axial Tomography (CAT scans) (revenue codes 350-352, 359); (iii) Hyperbaric oxygen (revenue code 413); (iv) Blood (revenue codes 380-399); and (v) Air ambulance (revenue code 545)."

    The Division finds that the requestor billed the following services that are eligible for additional reimbursement:

    Revenue code 350 for a CT scan at $1,896.25.

    Revenue code 610 for two MRIs at $3,942.50 and $3,148.50.

    Per 28 Texas Administrative Code §134.401(c)(4)(B), revenue codes 350 and 610 will be reimbursed at a fair and reasonable rate. The Division finds that revenue codes 350 and 610 shall be reimbursed pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
13. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

    - The requestor's position statement asserts that "Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred."
    - The requestor does not discuss or explain how additional payment of $32,805.72 would result in a fair and reasonable reimbursement.
    - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
    - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
    - The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:
    - "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources**.**
    - The requestor did not submit nationally recognized published studies or documentation of values assigned

for services involving similar work and resource commitments to support the requested reimbursement.

- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	9/19/2011 Date
Signature	Medical Fee Dispute Resolution Manager	9/19/2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.